Dr. Grame

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11691

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: PB-Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 104 E Chestnut St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Elizabeth Beauchamp — **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William Herbert Beauchamp
6.(c) If alive, give age: 52 years
7. Birth date of deceased (mo., day, yr.): April 10 - 1903

8. AGE: Years: 44 | Months: 7 | Days: 25 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Salisbury Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:

FATHER
12. Name: Silas Lecates
13. Birthplace: Wicomico Co. Md.

MOTHER
14. Maiden name: Sarah Campbell
15. Birthplace: Wicomico Co. Md.

16. Informant: Mrs. Wm. Herbert Beauchamp
Address: 104 E. Chestnut St. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 8 - 1947 (month) (day) (year)
Cemetery or crematory: Wicomico Mem. Park
Location: Salisbury Md

18. Funeral director: Dillon & Walter R. Holloway
Address: Salisbury Maryland

19. 12/8/47 (Date rec'd by registrar) 19 47 — Edward E. Johnson, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 5th 1947 at 3:35 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Prior 1946 to Dec 5 1947 and that I last saw h.. alive on Dec 5 1947

Immediate cause of death	DURATION
Uremia	
Due to: Hypertension	
Due to:	
Other conditions: Lobar pneumonia complicating (Include pregnancy within 3 months of death)	

Major findings of operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury: ..... Injured at work?

23. SIGNATURE: L. R. Grame M.D. — M. D. or other
Address: Salisbury Md. Date signed: 12/6/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Gilmore

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11692

92 B

Reg. Dist. No. 383

1. PLACE OF DEATH: County Wicomico; City or town Salisbury (If outside city or town limits, write RURAL and give nearest town); How long in above place of death?; Hospital, institution, or street address where death occurred: Peninsula Gen. Hosp.; How long in hospital or institution? 5 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State Md. County Wicomico; City or town Salisbury (If outside city or town limits, write RURAL and give nearest town); Street No. R.D. # 2 (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Eva June Bowden

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) June 3rd 1931

8. AGE: Years 16 | Months 6 | Days 6 | If less than one day hrs. min.

9. Birthplace Salisbury Md (Town, county, and state)

10. Usual occupation at Home

11. Industry or business

FATHER — 12. Name Thomas L. Bowden

13. Birthplace Whaleyville Md.

MOTHER — 14. Maiden name Minnie Marie Layfield

15. Birthplace Deal Island Md.

16. Informant Mr. Thomas L. Bowden

Address R.D. #2 Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 13-47 (month) (day) (year)

Cemetery or crematory Parsons Cem.

Location Salisbury Md

18. Funeral director Hillard & C. Walter R. Wilson

Address Salisbury Md

19. 12/11/47 (Date rec'd by registrar) W.T. Bassett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 9th 1947 at 11:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946 to Dec. 9 1947 and that I last saw h.. alive on Dec. 9 1947

Immediate cause of death	DURATION
Myocardial Insufficiency	1 yr.
Due to Rheumatic Heart Disease	Symptoms 1 yr.
Mitral Stenosis	
Due to Rheumatic Fever	1 yr.
Other conditions Recurrent acute Rheumatic fever	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations —

Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE J. David Gilmore M.D. M. D. or other

Address 504 Camden Ave Salisbury, Md. Date signed Dec. 12 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Nock

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1316

11693

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Peninsula Gen. Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D. #3
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George W. Byrd

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Hamilt E. Byrd
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): June 26-1863
8. AGE: Years: 84 Months: 5. Days: 24 If less than one day ..... hrs. ..... min.
9. Birthplace: Wicomico C. Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business:
FATHER 12. Name: George Byrd
13. Birthplace: Wicomico C. Md.
MOTHER 14. Maiden name: Louisa Johnson
15. Birthplace: Wicomico C. Md
16. Informant: Mrs. Lester Byrd
Address: R.D. #4. Salisbury Md.
17. Burial (Burial, cremation, or removal): Date thereof: Dec 22-47 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md.
18. Funeral director: Walter R. Holloway
Address: Salisbury Md.
19. 12/22/47 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 20th 1947 at 1245 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1947, to Dec 20 1947
and that I last saw h[illegible] alive on Dec 20 1947
Immediate cause of death: Chr. Myocarditis, Chr. Nephritis — DURATION: Yrs.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: —
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of
Where did injury occur? — (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Salisbury Date signed 12/22/47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.


JAN 14 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170 C

11694

CERTIFICATE OF DEATH

Reg. Dist. No. 133

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Willards

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME James Robert Campbell

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male.	W	S.

6.(b) Name of husband or wife: L

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 27, 1927

8. AGE:

Years	Months	Days	If less than one day
20	2	26	..... hrs. ..... min.

9. Birthplace: Ocean City (Town, county, and state)

10. Usual occupation: Helper Electrician

11. Industry or business

FATHER

12. Name: Denwood Campbell

13. Birthplace: Delaware

MOTHER

14. Maiden name: Gladys Donaway

15. Birthplace: Md. -

16. Informant: Mrs. Gladys Campbell

Address: Willards, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/27/47 (month) (day) (year)

Cemetery or crematory: Salisbury Cem.

Location: Salisbury, Md.

18. Funeral director: M. Leka Watson

Address: Selbyville, Del.

19. 12/27/47 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/23/1947 at 7 20 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/23/1947 to ..... 19..; and that I last saw h... alive on 12/23/1947

Immediate cause of death	DURATION
Due to: Fractured Skull	
Due to: Auto - accident	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of 12/20/47

Where did injury occur? Harvel's Crossing (City or town) Wicomico (County) Md. (State)

Injured at home, farm, industry, public place (where?) Highway 113

Means of injury: Auto struck a tree Injured at work? No

23. SIGNATURE AND TITLE OF PHYSICIAN: [illegible] M. D.

M. D. or other

Address: Pocomoke City, Md. Date signed: 12/23/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

166 11695

CERTIFICATE OF DEATH

Reg. Diat. No. 933

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 604 East Church Street

(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3. (a) FULL NAME: Corbin, Elwood

3. (b) Social Security Number: 214-10-6972

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	?

6.(b) Name of husband or wife: Carrie Corbin

6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): 6-11-1917

8. AGE: Years	Months	Days	If less than one day
30	5	21	...hrs. ...min.

9. Birthplace: Princess Anne, Somerset Co. Maryland (Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business: Sama

FATHER

12. Name: Lafayette Corbin

13. Birthplace: Eden, Somerset Co. Maryland

MOTHER

14. Maiden name: Lydia Cottman

15. Birthplace: Princess Anne, Somerset Co. Md.

16. Informant: Mrs. Lydia Bell

Address: 109 Catherine St. Salisbury, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-7-47 (month) (day) (year)

Cemetery or crematory: West Post Office

Location: West Post Office, Somerset Co. Md.

18. Funeral director: James F. Stewart

Address: 402 E. Church St. Salisbury Md.

19. 12/11/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 2 1947, at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19... and that I last saw ... alive on ... 19...

Immediate cause of death	DURATION
Bullet wound of Brain	3 hrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Justifiable Homicide Date of: 12/2/47

Where did injury occur? Salisbury (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?): None

Means of injury: Shot by police Injured at work? No

escaping from Burglary

23. SIGNATURE: J. A. Rademacher M.D.

Deputy medical Examiner or other

Address: Salisbury Md. Date signed: 12/2/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr Emrich
Hebron. md

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

31 11696

Reg. Dist. No. 833

1. PLACE OF DEATH:
County: Wicomico county
City or town: Rockawalking Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Rockawalking Md
(If outside city or town limits, write RURAL, and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Lenard J Corbin.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	Single Married

6.(b) Name of husband or wife: Nellie V Davis
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 18. 1916

8. AGE: Years: 31 | Months: - | Days: - | If less than one day: hrs. min.

9. Birthplace: Crisfield md. (Town, county, and state)

10. Usual occupation: Laborer.

11. Industry or business: none

FATHER
12. Name: George Corbin
13. Birthplace: Somerset Co.

MOTHER
14. Maiden name: Mary Dashiells
15. Birthplace: Wicomico Co Md.

16. Informant: Mary Corbin
Address: Rockawalking

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 10 1947 (month) (day) (year)
Cemetery or crematory: Flower Hill Cem
Location: Eden Md

18. Funeral director: Booker M. Guest
Address: 715½ Lake St. Salisbury

19. 12/10/47 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 4th 1947 at 12:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 14th 1947 to Dec. 3rd 1947 and that I last saw h alive on Dec. 3-1947

Immediate cause of death	DURATION
Pulmonary Tuberculosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: William Emrich M. D.
Address: Hebron Md Date signed: Dec. 6-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

11697

CERTIFICATE OF DEATH

Reg. Dist. No. 937

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury, Delmar Rd.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 weeks

Hospital, institution, or street address where death occurred: Passwater Nursing Home

How long in hospital or institution? 6 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Princess Anne, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No. R. D. #1, Mt. Vernon

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Annie Louisa Costen

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Henry J. Costen

6.(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): November 9, 1867

8. AGE:

Years	Months	Days	If less than one day
80	1	20	..... hrs. ..... min.

9. Birthplace: Somerset Co., Maryland (Town, County, and State)

10. Usual occupation: Gt. Lone

11. Industry or business: ✓

FATHER — 12. Name: George L. Bruington

13. Birthplace: Wicomico Co., Maryland

MOTHER — 14. Maiden name: Elizabeth Taiverse

15. Birthplace: Somerset Co., Maryland

16. Informant: Clyde M. Costen

Address: Princess Anne, Md., R. D. #1

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/31/47 (month) (day) (year)

Cemetery or crematory: Grace Episcopal Church

Location: Mt. Vernon, Maryland

18. Funeral director: The Hill Johnson Co.

Address: Salisbury, Maryland

19. 12/31 (Date rec'd by registrar) 19 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 29, 19 47 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 12 19 47, to Dec 29 19 47

and that I last saw h.e alive on December 29 19 47

Immediate cause of death	DURATION
Septicemia	
Due to Pelvic-rectal abscess	
Due to Ischio -	
Other conditions Arteio - sclerosis	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE: Lloyd D. Gramm M.D. M. D. or other

Address: Salisbury, Md. Date signed 12/29/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

Moyer

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131a B

11746

Reg. Dist. No. 008

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution? 31 hrs. 25 mins.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Delaware County Sussex

City or town Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Culver, Mrs. Ella

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife William S.H. Culver

6.(c) If alive, give age —— years

7. Birth date of deceased (mo., day, yr.) Mch. 4 - 17 1866

8. AGE: Years 80 | Months 9 | Days 13 | If less than one day ..... hrs. ..... min.

9. Birthplace Delaware (Town, county, and state)

10. Usual occupation Home Work

11. Industry or business " "

FATHER 12. Name William Brown

13. Birthplace Delaware

MOTHER 14. Maiden name Eliza Roberson

15. Birthplace Del

16. Informant George Merritt

Address Salisbury Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-20-47 (month) (day) (year)

Cemetery or crematory Odd Fellows Cemetery

Location Laurel Del

18. Funeral director Riggin & Cooper

Address Laurel Del

19. 12/18/47 (Date rec'd by registrar) 19 H.L. Bassett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 17th 1947, at 11 45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/1/47 to 12/17/47 19 47

and that I last saw h Cy alive on 12/17/47 19

Immediate cause of death	DURATION
(a) Uremia -	
Due to Arteriosclerotic Cardio-Vascular Disease	
Due to (b) Nephrosclerosis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Charles M. Moyer M. D., or other

Address Laurel Del Date signed .....

VS A15 9-25-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


JAN 14 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

13C 11698

Reg. Dist. No. 330

1. PLACE OF DEATH:

County Wicomico

City or town Mardela Springs - Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:
Mardela - Vienna Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland Couoty Wicomico

City or town Mardela Springs - Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Mardela - Vienna Road
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Lear A. Dashield

3.(b) Social Security Number 217-05-3994

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married

6.(b) Name of husband or wife Clifton Dashield

6.(c) If alive, give age 40 years

7. Birth date of decessed (mo., day, yr.) January 7, 1911

8. AGE: Years	Months	Days	If less than one day
36	11	6	....hrs. ....min.

8. Birthplace Sussex County Delaware
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER 12. Name John Cook

13. Birthplace Sussex County, Delaware

MOTHER 14. Maiden name Daisey Nabler

15. Birthplace Wicomico County, Maryland

16. Informant Clifton Dashield

Address Mardela Springs, Maryland R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof December 16, 1947 (month) (day) (year)

Cemetery or crematory Mardela Colored Cemetery

Location Mardela Springs Maryland R.F.D.

18. Funeral director J.J. Frampton Red Son

Address Federalsburg, Maryland

19. 12/16/47 (Date rec'd by registrar) 19.... W.H. Robertson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 13 1947, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 10 1947, to Dec. 12 1947 and that I last saw h.. alive on Dec 12 1947

Immediate cause of death	DURATION
Gradual Decline	
Due to Deabetes and Complications, (Diabetes)	
Due to Was positive for Tuberculosis	
Other conditions	

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W.D.C. Dunn M. D. or other

Address Mardela Springs Md Date signed Dec. 15 47

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11699

830a Tr.

Reg. Dist. No. 933

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mo 18 Days
Hospital, institution, or street address where death occurred: 105 Lehmy Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: No ✓

3.(a) FULL NAME: James Edward Duer

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Margaret A. Duer
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 16 – 1864

8. AGE: Years: 83 | Months: 9 | Days: 18 | If less than one day: hrs. min.

9. Birthplace: Snow Hill Worcester, Md (Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business:
FATHER 12. Name: John Duer
13. Birthplace: Maryland
MOTHER 14. Maiden name: Mary Maddox
15. Birthplace: Maryland
16. Informant: Mrs Lester D. Mock
Address: Snow Hill, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 6/47 (month) (day) (year)
Cemetery or crematory: Bates Methodist
Location: Snow Hill, Md
18. Funeral director: Elay E. Dennis
Address: Snow Hill, Md
19. 12/5 (Date rec'd by registrar) 19 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 4 19 47, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1st 19 47, to December 4th 19 47 and that I last saw him alive on December 1st 19 47

Immediate cause of death	DURATION
Cerebral Hemorrhage, left	4 days
Due to	
Due to	
Other conditions: Uremia	?
Previous cerebral hemorrhage (Include pregnancy within 3 months of death)	?

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: S. V. Fokler M.D. M. D. or other
Address: Delmar, Del Date signed: 12-4-47

VS A15 9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11700

526

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Pittsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Pittsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Augustus Webster Eldredge

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 13-1883

8. AGE: Years	Months	Days	If less than one day
64	10	17	hrs. min.

9. Birthplace: Sussex Co. Delaware
(Town, county, and state)

10. Usual occupation: Laborer
11. Industry or business

MOTHER FATHER
12. Name: Hanna M. Eldredge
13. Birthplace: Adams Co. Pa.
14. Maiden name: Emily Virden
15. Birthplace: Dover / Delaware

16. Informant: Mr. Laurence C. Freeny
Address: Pittsville Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Jan. 2, 1948 (month) (day) (year)
Cemetery or crematory: Macdela Cem.
Location: Macdela Maryland

18. Funeral director: Holloway & Walter L. Holloway
Address: Salisbury Md.

19. (Date rec'd by registrar) 1/2, 1948 Registrar: Bessie E. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 30th 1947 at 11:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1, 1947 to day of death and that I last saw h alive on 12-30-47.

Immediate cause of death	DURATION
Carcinoma Primary bladder and prostate gland.	2 mos?
Due to	
Due to	
Other conditions: Asthma, Chronic bronchitis 15 yrs.	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

25. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Nature of injury Injured at work?

23. SIGNATURE: Frank Lewis M.D. M. D. or other
Address: Pittsville Md. Date signed 1-2-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

58 X 11711

Reg. Dist. No. X 336

1. PLACE OF DEATH:

County Wicomico

City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, Institution, or street address where death occurred:
421 East Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)

Street No. 421 East
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Ernest Gordy

3.(b) Social Security Number ------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

B.(b) Name of huaband or wife ----------

6.(c) If alive, give age ---- --- years

7. Birth date of deceased (mo., day, yr.) March 18, 1935

8. AGE:	Years	Months	Days	If less than one day
	12	9	6	....hrs. ....min.

9. Birthplace Delmar, Maryland
(Town, county, and state)

10. Usual occupation School Student

11. Industry or business Delmar. Maryland School,

FATHER
12. Name J.William Gordy
13. Birthplace Delmar, Maryland

MOTHER
14. Maiden name Isabelle Figgs
15. Birthplace Pittsville, Maryland

16. Informant J. W. Gordy

Address Delmar, Del.

17. Burial (Burial, Cremation, Which?) Date thereof 12-26-47 (month) (day) (year)

Cemetery or ~~crematory~~ Mt. Olive Methodist

Location Delmar, Delaware

18. Funeral director W. S. Gaynd Co

Address Delmar, Delaware

December 26 1947 Harry E. Hudson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 24th 1947, at 8.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 10 1947, to Dec 24 1947

and that I last saw him alive on Dec 24 1947

Immediate cause of death	DURATION
Acute cardiac failure	24 hrs
Due to Rheumatic Fever	7 mos
Due to Rheumatic Endocarditis	5 mos
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE J. W. Gordy M. D. or other

Address Delmar Del. Date signed Dec 25 47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 b

11702

CERTIFICATE OF DEATH

Reg. Dist. No. 337

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since Dec. 11, 1947

Hospital, institution, or street address where death occurred:

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Georgia County: Calhoun

City or town: Cordele

(If outside city or town limits, write RURAL and give nearest town)

Street No.: no

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3. (a) FULL NAME: Anderson Green

3. (b) Social Security Number: 258-20-1571

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	a.a.	

6.(b) Name of husband or wife: Viola Green

6.(c) If alive, give age: don't know years

7. Birth date of deceased (mo., day, yr.): 6-10-1890

8. AGE:

Years	Months	Days	If less than one day
57	6	14	...hrs. ...min.

9. Birthplace: Easton Georgia (Town, county, and State)

10. Usual occupation: Laborer

11. Industry or business: Same as above

FATHER

12. Name: John Green

13. Birthplace: Cusbus, Georgia

MOTHER

14. Maiden name: Ella Green

15. Birthplace: Cusbus, Georgia

16. Informant: Mrs. Maggie Ray

Address: E. Church St, Salisbury Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 31-1947 (month) (day) (year)

Cemetery or crematory: whit Set

Location: Cordele Ga

18. Funeral director: James F. Stewart

Address: 402 E. Church St. Salisbury Md.

19. 12/29/47 (Date rec'd by registrar) Maggie A. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 24 1947, at ...M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 15-1947 to Dec 24 1947

and that I last saw him alive on Dec 24 1947

Immediate cause of death: Chronic Myocarditis & acute cardiac failure — DURATION

Due to:

Due to:

Other conditions: Chronic nephritis arteriosclerosis.

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ...Injured at work?

23. SIGNATURE: Thos A Tuohy M. D. or other

Address: Salisbury Md Date signed 12-27-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

dr. Rademaker

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

59 b

11703

Reg. Dist. No. 733

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 10 hrs - 45 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Worcester

City or town: Newark

(If outside city or town limits, write RURAL and give nearest town)

Street No.: no

(If rural, give LOCATION)

2.(a) If veteran, name war: no ✓

3.(a) FULL NAME: Hammond, Lewell

3.(b) Social Security Number: no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: no

6.(c) If alive, give age: no years

7. Birth date of deceased (mo., day, yr.): about 1802

8. AGE: Years: 65 | Months: — | Days: — | If less than one day: ... hrs. ... min.

9. Birthplace: Newark md (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Same as above

FATHER — 12. Name: Amos Hammond

FATHER — 13. Birthplace: Newark md

MOTHER — 14. Maiden name: Alice Collins

MOTHER — 15. Birthplace: Newark md

16. Informant: Randolph Dennis

Address: Newark md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 29 1947 (month) (day) (year)

Cemetery or crematory: Cedar Chapel

Location: Newark Md

18. Funeral director: James H Stewart

Address: Salisbury md

19. 12/27/47 (Date rec'd by registrar) Harriet L Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 26 1947, at 4 55 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 24 1947 to Dec 26 1947 and that I last saw h... alive on Dec 26 1947

Immediate cause of death	DURATION
Glomerulo nephritis chronic	6 weeks
Due to: arterio sclerosis	1 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none ... Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide: ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

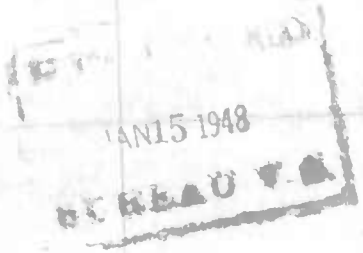
23. SIGNATURE: J A Rademaker M. D. or other

Address: Salisbury Md Date signed: 12/27/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


JAN15 1948

(Ex Park (admitted 10/22/47)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46d

11704

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Delaware County: Sussex

City or town: Laurel

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D. #2

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Henry, Mr. Lillard T.

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married ✓

6.(b) Name of husband or wife: Pearl Henry

6.(c) If alive, give age: 21+ years

7. Birth date of deceased (mo., day, yr.): Sept 17 - 1881

8. AGE: Years	Months	Days	If less than one day
66	2	29	✓ hrs. ✓ min.

9. Birthplace: Delaware (Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business: ✓

FATHER — 12. Name: Wm. B. Henry

FATHER — 13. Birthplace: Delaware

MOTHER — 14. Maiden name: Mahala E. Mackenzie

MOTHER — 15. Birthplace: Delaware

16. Informant: Pearl Henry

Address: Laurel Del.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 20-47 (month) (day) (year)

Cemetery or crematory: Mt Pleasant Cemetery

Location: Laurel Del

18. Funeral director: J. L. Rickards

Address: Laurel Del.

19. (Date rec'd by registrar) 12/18, 19 47 Registrar: Mabel C. Johnson

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 17 19 47 at 10 50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 19 47, to Dec 17 19 47 and that I last saw h[illegible] alive on Dec 17 19 47

Immediate cause of death	DURATION
Carcinoma of Rectum	
C Metastasis to Liver	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Laud Date of op. 11/14/47

Autopsy results: ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ✓ Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: [illegible] Date signed: 12/18/47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct page is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of year of birth is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11705

131a

FILM No. G 114 JAN 23 1948

CERTIFICATE OF DEATH

Reg. Dist. No. 233

1. PLACE OF DEATH:
County: Wicomico
City or town: Pittsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For new-born infants give residence of mother)
State: Md. County: Wicomico
City or town: Pittsville
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Bertha Ellen Holland

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: James W. Holland
6.(c) If alive, give age: Dead years
7. Birth date of deceased (mo., day, yr.): April 29 - 1880

8. AGE: Years 67 | Months 7 | Days 27 | If less than one day: hrs. min.

9. Birthplace: Pittsville Md.
(Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business: at Home
FATHER 12. Name: Hiram J. Bunting
13. Birthplace: Pittsville Md.
MOTHER 14. Maiden name: Laura Powell
15. Birthplace: Pittsville Md
16. Informant: Mr. Carlton B. Holland
Address: 300 Washington St. Salisbury Md
17. Burial, cremation, or removal. Which?: Burial Date thereof: Dec 28 47 (month) (day) (year)
Cemetery or crematory: St. Johns Cem.
Location: Pittsville Md
18. Funeral director: Fillmore & Walter R. Tilghman
Address: Salisbury Md
19. 12/27/47 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 26 - 1947 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 2 1947 to day of death 1947 and that I last saw h[illegible] alive on 12-26-47. 1947

Immediate cause of death — DURATION
Chronic myocarditis. 2 yrs.
Chronic Int. nephritis.
Due to: Arteriosclerosis.
Due to:
Other conditions: Hyperextension
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Frank P. Lewis M.D.
M. D. or other
Address: Hebron Md Date signed 12-28-47.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

92d

11706

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 years

Hospital, Institution, or street address where death occurred:
332 New York Ave.,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No. 332 New York ave.,
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Frank Thomas Holland

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ida Massey Holland

6.(c) If alive, give age: 83 years

7. Birth date of deceased (mo., day, yr.): July 8, 1862

8. AGE: Years: 85 Months: 5 Days: 14 If less than one day: ____ hrs. ____ min.

9. Birthplace: St. Martins, Worcester Co., Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Storekeeper

FATHER
12. Name: Jesse Thomas Holland
13. Birthplace: Worcester Co., Md.

MOTHER
14. Maiden name: Elizabeth Ann Lane
15. Birthplace: Worcester Co. Md.

16. Informant: W. Tracy Holland
Address: Salisbury, Maryland

17. Burial (Burial, cremation, or removal Which?) Date thereof 12/24/47 (month) (day) (year)

Cemetery or crematory: Parsons Cemetery

Location: Salisbury, Maryland

18. Funeral director: The Adkins & Johnson Co.

Address: Salisbury, Maryland

19. 12/24/47 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 22 19 47 at 6:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 24 to Dec 22 19 47 and that I last saw h[illegible] alive on Dec 22 19 47

Immediate cause of death	DURATION
Valvular Heart Disease	23 yrs
Due to	
Due to	
Other conditions: Hypertension	28 yrs
Paralysis from stroke	28 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: 8-30

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Steve R Mann M. D. or other

Address: 1127 Dalby Rd Date signed: 12/24/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M


RECEIVED
JAN 14 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

169

11707

CERTIFICATE OF DEATH

Reg. Diat. No. 999

W

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: P.R.R. Tracks
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 101. Pond St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Ralph Hughes

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 27-1877

8. AGE: Years: 70. Months: 1 Days: 27 If less than one day: ..... hrs. ..... min.

9. Birthplace: Neanna Maryland (Town, county, and state)

10. Usual occupation: Labor

11. Industry or business: On Chesapeake Bay Boats

FATHER
12. Name: James Hughes
13. Birthplace: Dorchester Co. Md

MOTHER
14. Maiden name: Josephine Hurley
15. Birthplace: P.O. Neanna Md.

16. Informant: Mrs. Nettie M. Hurley
Address: 101. Pond St. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 26-47 (month) (day) (year)
Cemetery or crematory: Sal. Mem. Park
Location: Salisbury Md

18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md.

19. 12/26/47 (Date rec'd by registrar) Harriet E. Johnson Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 29 47, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Medical Exam Embalmed 19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Decapitation	Sudden deaths
Due to: amputated both legs	
Lacerations of abdomen	
Due to: amputations Head	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
No. Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of 12-24-47
Where did injury occur? Salisbury (City or town) Wicomico (County) Md (State)
Injured at home, farm, industry, public place (where?) P.R.R. track
Means of injury: struck by train Injured at work? No

23. SIGNATURE: Sam Rodemeyer deputy Medical Examiner
M. D. or other
Address: Salisbury Md Date signed 12/27/47

VS-A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.


RECEIVED
JUN 14 1948

W Rademaker

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

11708

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Wicomico

City or town Fruitland Md

(If outside city or town limits, write RURAL and give nearest town)

Street No. no

(If rural, give LOCATION)

2.(a) If veteran, name war no

3.(a) FULL NAME Jones, William

3.(b) Social Security Number no

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife no

no 6.(c) If alive, give age no years

7. Birth date of deceased (mo., day, yr.) May 21 1932

8. AGE: Years 15 Months Days If less than one day ....hrs. ....min.

9. Birthplace Salisbury Md (Town, county, and state)

10. Usual occupation School Boy

11. Industry or business no

FATHER 12. Name Herbert Jones

13. Birthplace Pilot Mech N. C.

MOTHER 14. Maiden name Alene Neal

15. Birthplace Wendell N. C.

16. Informant Herbert Jones

Address Fruitland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 24 1947 (month) (day) (year)

Cemetery or crematory Mt Olivet

Location Fruitland Md

18. Funeral director James H Stewart

Address Salisbury Md

19. 12/26/47 (Date rec'd by registrar) 19 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 22 19 47 at 5 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~Dec~~ 19 to 19

and that I last saw h... alive on 19

Immediate cause of death Compound fracture of Skull — Brain injury — DURATION 1 Hour

Due to

Due to

Other conditions Compound fracture of Left Tibia

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op.

None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 12/22/47

Where did injury occur? Allen (City or town) Wicomico (County) Md (State)

Injured at home, farm, industry, public place (where?) Highway

Means of injury Pedestrian struck by car Injured at work? No

23. SIGNATURE L A Rademaker M.D. M. D. or other

Address Salisbury Md Date signed 12/22/47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.


RECEIVED
JAN 14 1948

Dr. Frame

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

958

11709

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
P. S. Boyd
How long in hospital or institution? twenty minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infant, give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 311 Franklin Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Ida Jeanette Lawrence

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Norman W. Lawrence
6.(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): July 4 - 1921

8. AGE: Years: 26 Months: 5 Days: 11 If less than one day: hrs. min.

9. Birthplace: Salisbury Md.
(Town, county, and state)

10. Usual occupation: Home life

11. Industry or business:

FATHER
12. Name: William E. Maddox
13. Birthplace: Salisbury Md.

MOTHER
14. Maiden name: Edna E. Smith
15. Birthplace: Chad Point Md.

16. Informant: Mrs. Norman W. Lawrence
Address: 311 Franklin Ave. Salisbury Md.

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Dec. 17-47 (month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Maryland

18. Funeral director: Wilbur E. Walter Robertson
Address: Salisbury Md.

19. 12/17/1947 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 15th 1947 at 3a m

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Mar 1945 to Dec 15 1947 and that I last saw her alive on Dec 15 1947

	DURATION
Immediate cause of death: Acute Congestive Heart Failure	3 hrs
Due to: Arteriosclerotic Heart Disease	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Fred R. Freeman M.D. M. D. or other
Address: Salisbury, Md. Date signed: 12/17/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

Dr. Cramer

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

11710

CERTIFICATE OF DEATH

Reg. Diat. No. 9 33

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: R.D. #3 Salisbury Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. RD #3
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Amelia Hester Layfield

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Handy W. Layfield
6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): June 2 - 1862

8. AGE:

Years	Months	Days	If less than one day
85	6	8	hrs. min.

9. Birthplace: Powellville Md.
(Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business: at Home

FATHER
12. Name: James Evans
13. Birthplace: Powellville Md.

MOTHER
14. Maiden name: Priscilla Parsons
15. Birthplace: Powellville Md.

16. Informant: Mrs. Edna B. White
Address: RD #3. Salisbury Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Dec 12-47 (month) (day) (year)
Cemetery or crematory: Mount Lowe Cem.
Location: Near Parsonsburg Md
18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md

19. 12/12/47 H.C. Barrick E. S. Johnson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 10 - 1947 at 12 o'c M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 1946 to Dec 10 1947 and that I last saw h.. ex.. alive on Dec 9 1947

Immediate cause of death	DURATION
Uraemia	
Underlying cause: Nephrosclerosis	
Due to Hypertension & Arthritis advanced [1/23/48 ulc]	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Manner of injury: Injured at work?

23. SIGNATURE: Fred D. Cramer M. D. or other
Address: Salisbury, Md. Date signed 12/20/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45.15

Dr. Nock

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

117a 11711

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 7 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Worcester

City or town Girdletree

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION) RD No 2 ✓

2.(a) If veteran, name war

3. (a) FULL NAME Maddox Mr. Charles W.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Maddox Mrs. Sadie

6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) June 12 - 1874

8. AGE:

Years	Months	Days	If less than one day
73	6	15	hrs. min.

9. Birthplace Solomons Island Virginia (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Sylvester Maddox

13. Birthplace Maryland

MOTHER 14. Maiden name Martha Kelly

15. Birthplace Maryland

16. Informant Mrs Sadie Maddox

Address Girdletree, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 29/47 (month) (day) (year)

Cemetery or crematory Bethbeley

Location Snow Hill Md

18. Funeral director Leby E. Timmons

Address Snow Hill Md

19. Dec. 27, 1947 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 27 1947 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1947 to Dec 27 1947 and that I last saw him alive on Dec 27 1947

Immediate cause of death	DURATION
Coronary Occlusion Chronic Myocarditis	3 dys Indef.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op. 12/10/47

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Girdletree Date signed 12/29/1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11712

CERTIFICATE OF DEATH

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury R.F.D. Quantico Rd
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Wicomico
City or town: Salisbury R.F.D. Quantico Rd
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Levin Richard Jennick

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife: Maggie Ellen Jennick
6.(c) If alive, give age 66 years
7. Birth date of deceased (mo., day, yr.): June 21, 1877

8. AGE: Years	Months	Days	If less than one day
70			hrs. min.

9. Birthplace: Nettingim, Wicomico, Md. (Town, county, and state)
10. Usual occupation: Laborer, retired 3 yrs.
11. Industry or business: State Rds. Comm.
FATHER 12. Name: Asbury Jennick
13. Birthplace: Nettingim Md.
MOTHER 14. Maiden name: Elizabeth Smith
15. Birthplace: Nettingim Md.
16. Informant: Mrs. Samuel Hopkins
Address: Hebron Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 14, 1947 (month) (day) (year)
Cemetery or crematory: Nettingim Cemetery
Location: Nettingim Md.
18. Funeral director: David R. Messick
Address: Hebron Md.
19. 12/14 1947 Emmit L. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 11, 1947, at 8:20 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 8th 1947, to December 11th 1947, and that I last saw him alive on Dec. 11th 1947.

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions: Arteriosclerosis	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: William Emrich M. D. or other
Address: Hebron Md. Date signed Dec 12-47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11748

159

Reg. Dist. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Salisbury, Md. (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Worcester

City or town Berlin (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Miller Bobby Esley

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	C	

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) November 30, 1947 at 6 a.m.

8. AGE: Years | Months | Days: 18 | If less than one day: ... hrs. ... min.

9. Birthplace Salisbury, Wicomico, Maryland (Town, county, and state)

10. Usual occupation Child

11. Industry or business

FATHER 12. Name Miller, Hoyal

FATHER 13. Birthplace Trenton, N. C.

MOTHER 14. Maiden name Hilda Grace

MOTHER 15. Birthplace Kinston, N. C.

16. Informant Elizabeth Tatton (aunt)

Address Berlin, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof 12/2/47 (month) (day) (year)

Cemetery or crematory Peninsula General Hospital

Location Salisbury, Md.

18. Funeral director Peninsula General Hospital

Address Salisbury, Md.

19. 12/2/47 (Date rec'd by registrar) 19 H. Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 18 - 1947 at 11 35 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 December 1947, to 18 Dec. 1947 and that I last saw h. l. alive on 18 December 1947

Immediate cause of death	DURATION
Prematurity	18 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results. Prematurity

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE Lee Kerr, M.D. M. D. or other

Address Salisbury, Maryland Date signed 12/20/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15


JAN 14 48
BUREA

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11743

94a

Reg. Diat. No. 333

1. PLACE OF DEATH:

County Wicomico

City or town Fruitland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hoepital, Inetitution, or street addrees where death occurred:

at Home

How long in hoepital or Inetitution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Wicomico

City or town Fruitland

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veleran, name war

3.(a) FULL NAME Harry M. Morris

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Irene H. Morris

6.(c) If alive, give age: 35 years

7. Birth date of deceased (mo., day, yr.): Dec. 9, 1903

8. AGE: Years: 44 Months: 8 Daye: 3 If leee than one day: hrs. min.

9. Birthplace: Illinois (Town, county, and state)

10. Ueual occupation: Service Station attendant

11. Indueiry or buelneee

FATHER 12. Name: Howard Morris

13. Birthplace: Illinois

MOTHER 14. Maiden name: Cryfy Wood

15. Birthplace: Illinois

16. Informant: Mrs Harry M. Morris

Address: Fruitland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-14-47 (month) (day) (year)

Cemetery or crematory: St andrew Cemetery

Location: Princess Anne, Md

18. Funeral director: Wilson Funeral Home

Addreee: Princess Anne, Md

19. 12/14/47 (Date rec'd by registrar) H. L. Kasser E. E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 12 19 47 at 1 30 P. M

21. I CERTIFY that death occurred on the date above etated; that I attended deceaeed from 12-12- 19 47 to 12-12 19 47 and that I laet eaw h. alive on 12-12-47 19

Immediate cauee of death	DURATION
Coronary Thrombosis	1 da
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy reeults

PHYSICIAN: Please uoderline the cauee to which death ehould be charged etatietically.

22. VIOLENCE: If death was due to external cauees, fill in the following:

Accident, euicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Indueiry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Lee L Lowery M. D. (M. D. or other)

Addreee Fruitland Md Date signed 12-12-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

11714

1700

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 393

MV

W

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Peninsula General Hospital
How long in hospital or institution? 16 days 13 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Pittsville (If outside city or town limits, write RURAL and give nearest town)
Street No. RD. #2 (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Morris Mr. Willie (Willie Edwin Morris)
3. (b) Social Security Number

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Single
6.(b) Name of husband or wife
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) May 1st 1932
8. AGE: Years 15 Months 7 Days 1 If less than one day ... hrs. ... min.
9. Birthplace RD. #2 Pittsville Md. (Town, county, and state)
10. Usual occupation School Boy
11. Industry or business Wi. Co. C. High School.

FATHER
12. Name Willie Morris
13. Birthplace RD. #2 Pittsville Md.

MOTHER
14. Maiden name Nilsie Jones
15. Birthplace Powellville Maryland

16. Informant Mr. Willie Morris
Address RD. #2 Pittsville Maryland
17. Burial (Burial, cremation, or removal, Which?) Date thereof Dec. 5-1947 (month) (day) (year)
Cemetery or crematory St. Johns Cemetery
Location Powellville Maryland
18. Funeral director Holloway & C. Walter R. Holloway
Address Salisbury Maryland.
19. 12/3, 1947 Garrett J. Johnson (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 2 1947, at 8:20 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19... and that I last saw h... alive on ... 19... Medical ex. [illegible] not [illegible]

Immediate cause of death: Fractured skull, Brain injury — DURATION 16 days
Due to
Due to
Other conditions Terminal pneumonia — 1 days
(Include pregnancy within 3 months of death)
Major findings of operations none
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 11/26/47
Where did injury occur? near Fruitland Wicomico Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Highway
Means of injury Riding motorcycle collided c truck Injured at work? No
23. SIGNATURE J. A. Rodzyn[illegible] MD Deputy Med. Examiner M. D. or other
Address Salisbury Md. Date signed 12/2/47

I

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

11715

Reg. Diat. No. 333

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Peninsula General Hospital
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Delmar
(If outside city or town limits, write RURAL and give nearest town)
Street No. Elizabeth St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Anna May Pilgrim

3.(b) Social Security Number
---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Frank W. Pilgrim
6.(c) If alive, give age: ---
7. Birth date of deceased (mo., day, yr.): May 3, 1873

8. AGE: Years	Months	Days	If less than one day
74			hrs. min.

9. Birthplace: Deborah, Iowa (Town, county, and state)
10. Usual occupation: House work
11. Industry or business: Home

FATHER
12. Name: John Elwick
13. Birthplace: England

MOTHER
14. Maiden name: Mary JOnes
15. Birthplace: England

16. Informant: Mildred Bradley
Address: Delmar, Delaware

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-17-47 (month) (day) (year)
Cemetery or xxxx First Methodist
Delmar, Delaware
Location
18. Funeral director H. S. Mann Co
Address Delmar, Delaware
19. 12/17, 19 47 Received by Registrar

MEDICAL CERTIFICATION

P

20. DATE OF DEATH Dec. 15 19 47 at 12.40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 6 19 47 to Dec. 15 19 47 and that I last saw her alive on Dec. 14 19 47

Immediate cause of death	DURATION
(a) Hypostatic pneumonia	8 days
Due to (b) Cardiac failure	
Due to	
Other conditions Hypertensive heart disease	3 yrs ?

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. V. Fohler, M. D.
M. D. or other
Address Delmar, Del. Date signed 12-16-47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr. Gilmore

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

96

11716

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County... Wicomico

City or town... Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?...

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Somerset

City or town... Oriole

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war... ✓

3.(a) FULL NAME

Shelton, Mr. Lillian

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife... Fousa Shelton

6.(c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) June 1876

8. AGE: Years 71 Months Days If less than one day ... hrs. ... min.

9. Birthplace... Oriole Somr. Md.

(Town, county, and state)

10. Usual occupation... Oysterman

11. Industry or business... Waterman

FATHER 12. Name... William Shelton

13. Birthplace... Oriole Md.

MOTHER 14. Maiden name... Maria Davis

15. Birthplace... Oriole Md.

16. Informant... Fousa Shelton

Address... Oriole Md.

17. Burial Date thereof Dec 26-47

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Oriole M.E. Church

Location... Oriole Md.

18. Funeral director... H. Sterling Beauchamp

Address... Deal Island Md.

19. Dec 26 1947 Harriet E. Johnson Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH... December 24 1947, at 1:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 20 1947 to Dec. 24 1947 and that I last saw h.. alive on December 24 1947

	DURATION
Immediate cause of death... Aneurysm of Aorta	Symptoms
Due to... Arteriosclerosis	2 months
Due to...	
Other conditions Coronary Artery Arteriosclerosis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operation... —

Date of op...

Autopsy results... See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... — Date of...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)...

Means of injury... Injured at work?...

23. SIGNATURE David J. Gilmore M.D.

M. D. or other

Address... 504 Camden Salisbury Md. Date signed Dec 26 1947

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


RECEIVED
JAN 14 1948

Dr. Mann

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

11717

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH: Wicomico

County ..... Salisbury

City or town ..... (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, institution, or street address where death occurred: RD #4.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Wicomico

City or town Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No. RD #4. (If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME Abraham Smith

3. (b) Social Security Number 120-54-[illegible]

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Beatrice Smith

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 28-1861

8. AGE: Years 86 | Months 7 | Days 8 | If less than one day ..... hrs. ..... min.

9. Birthplace Wicomico Co. Md (Town, county, and state)

10. Usual occupation Retired

11. Industry or business Farmer

FATHER 12. Name Lampson Smith

13. Birthplace Wic Co. Md

MOTHER 14. Maiden name Hattie Taylor

15. Birthplace Wic. Co. Md.

16. Informant Charles A. Smith

Address RD #4. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 9-47 (month) (day) (year)

Cemetery or crematory Parsons Cem.

Location Salisbury Md

18. Funeral director Hollings & Walter R. Hollings

Address Salisbury Maryland

19. 12/9 (Date rec'd by registrar) 19 47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 6th 1947, at 12.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1947 to Dec 6 1947 and that I last saw h... alive on Dec. 6 1947

Immediate cause of death	DURATION
Cerebral Hemorrhage	2 days
Due to Hypertension	Unknown
Due to	
Other conditions Cardio-Vas-Renal	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Thos R Mann M. D. or other

Address Salisbury Md Date signed 12/2/47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

Fisher

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11749

46d

Reg. Dist. No. 323

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Jabout 8 years

Hospital, institution, or street address where death occurred: Peninsula General Hospital.

How long in hospital or institution? One week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME: Robert Taylor

3.(b) Social Security Number: 261-20-6903

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
male	a.a.	Married

6.(b) Name of husband or wife: Grace Taylor

6.(c) If alive, give age: 34 years

7. Birth date of deceased (mo., day, yr.): Aug 1898

8. AGE: Years	Months	Days	If less than one day
49	—	—	....hrs. ....min.

9. Birthplace: Whittman S.C. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Same as above

FATHER 12. Name: Unknown

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Unknown

16. Informant: Grace Taylor

Address: Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 5. 1948 (month) (day) (year)

Cemetery or crematory: Public

Location: Salisbury

18. Funeral director: James T. Stewart

Address: Salisbury, Md.

19. 1/6 1948 (Date received by registrar) Katharine L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 31st 1947, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/26 1947, to 12/31 1947, and that I last saw him alive on 12/31 1947.

Immediate cause of death	DURATION
Carcinoma of Liver	Several months
Due to Carcinoma of Stomach	"
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Carcinoma of Liver & Stomach. Date of op. 12-29-'47

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Clem T. Fisher M.D. (M. D. or other)

Address: Salisbury, Md. Date signed: 1/2 '48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

11718

CERTIFICATE OF DEATH

Reg. Dist. No. 933

1. PLACE OF DEATH

County: Wicomico

City or town: Nelson

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution or street address where death occurred: R.D. #1.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For children born in hospitals give residence of mother)

State: Md. County: Wicomico

City or town: Nelson

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.D. #

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Nettie Tracey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: William Tracey

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Aug. 15 - 1875

8. AGE: Years	Months	Days	If less than one day
72	3	26	hrs. min.

9. Birthplace: Fredericksburg Md. (Town, county, and state)

10. Usual occupation: Home Life

11. Industry or business

FATHER

12. Name: Harry Nelson

13. Birthplace: Fredericksburg Md

MOTHER

14. Maiden name: Rebecca Whittington

15. Birthplace: Fredericksburg Md

16. Informant: Mrs. Catherine Williamson

Address: 433 E. William St. Salisbury Md

17. (Burial, cremation, or removal. Which?) Burial Date thereof: Dec 19-47 (month) (day) (year)

Cemetery or crematory: Bethel Cem

Location: Nelson Md

18. Funeral director: Hellen & Walter Whaley

Address: Salisbury Md

19. (Date rec'd by registrar) 12/14/47 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 11th 1947 at 2300 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 1st 1947, to Dec. 11th 1947 and that I last saw h[illegible] alive on Dec. 10th. 1947

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions: Nephritis Chronic	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Was injury incident to employment? Injured at work?

23. SIGNATURE: William Emrich M. D. or other

Address: Nelson - Md Date signed: Dec. 11-47

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(I) MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

11710

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No. 506 North Division Street

(If rurel, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Jesse R. Wanner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Widower

6.(b) Name of husband or wife: Emily Wanner

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Nov. 28-1887

8. AGE: Years: 60 Months: 0 Days: 21 If less than one day: hrs. min.

9. Birthplace: Hutchtown Pa (Town, county, and state)

10. Usual occupation: Medical Doctor

11. Industry or business

FATHER — 12. Name: Enos H. Wanner

FATHER — 13. Birthplace: Hutchtown Pa

MOTHER — 14. Maiden name: Mary Mattie Roeinbuger

MOTHER — 15. Birthplace: Hutchtown Pa

16. Informant: Jesse R. Wanner Jr.

Address: 506 N. Div. St. Salisbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 21-1947 (month) (day) (year)

Cemetery or crematory: Fairview Cem.

Location: Hutchtown Pa, (Bucks County)

18. Funeral director: Hill Bros & G. Walter R. Hill

Address: Salisbury Md.

19. 12/20/47 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 19, 1947, at 12 40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/15 1947 to 12/19 1947 and that I last saw him alive on 12/19 1947

Immediate cause of death	DURATION
Cardio-renal Failure	about 2yrs
Uraemia	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury: Injured at work?

23. SIGNATURE: Edna V. Trimble M.D.

M. D. or other

Address: Salisbury Md. Date signed: 12-19-47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15


JAN 14 1948

11720

Dr. Fitts

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

14

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Peninsula General Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Somerset

City or town: Princess Anne
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.R. #1
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Weatherbe Baby Joseph

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 30 1946

8. AGE: Years: 1 | Months: 1 | Days: | If less than one day: hrs. min.

9. Birthplace: Peninsula General Hospital
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Beaver Weatherbe

13. Birthplace: North Carolina

MOTHER — 14. Maiden name: Bertha Handy

15. Birthplace: New York City

16. Informant: Beaver Weatherbe

Address: Princess Anne Md. R.R. #1

17. Burial, cremation, or removal. Which?: Burial Date thereof: Dec 21 47
(month) (day) (year)

Cemetery or crematory: St Paul

Location: Revells Neck, Md.

18. Funeral director: Williams & St. James Jr.

Address: Princess Anne, Md.

19. 12/20/47 (Date rec'd by registrar) 19 47 Garnett L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 19 1947 at 2:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 December 1947 to 19 Dec. 1947 and that I last saw h...im alive on 18 December 1947

Immediate cause of death: Tuberculous meningitis — DURATION: 4 weeks

Due to:

Due to:

Other conditions: Acute hepatitis — one week
(Include pregnancy within 3 months of death)

Major findings of operations: none — Date of op.:

Autopsy results: None done.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: A. Fitts, M.D.
M. D. or other

Address: 221/2 Camden Ave., Salisbury Date signed: 12/19/47

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M


JAN 14 1948

Dr. Stohler

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

50

11721

CERTIFICATE OF DEATH

Reg. Dist. No. 983

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred: RD #3
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED
(For new-born infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. RD #3
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Ann Whayland

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: M.
6.(b) Name of husband or wife: Charles J. Whayland
6.(c) If alive, give age: 57 years
7. Birth date of deceased (mo., day, yr.): May 27- 1888
8. AGE: Years: 59 Months: 6 Days: 13 If less than one day: hrs. min.
9. Birthplace: Va. (Town, county, and state)
10. Usual occupation: Home wife
11. Industry or business:

FATHER
12. Name: John Shockley
13. Birthplace: Worcester Co. Md

MOTHER
14. Maiden name: Martha Isacallette
15. Birthplace: Somerset Co. Md

16. Informant: Mr. Charles J. Whayland
Address: RD #3 Salisbury Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Dec. 18-47
(month) (day) (year)
Cemetery or Crematory: Parsons Cem Dec. 13-47
Location: Salisbury Md

18. Funeral director: Holloway & Co. Walter R. Holloway
Address: Salisbury Md.

19. 12/13/47 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 10- 1947 at 4:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1947 to Dec 10 1947
and that I last saw h[illegible] alive on Dec 9 1947

Immediate cause of death: Cancer of left breast with multiple meta-stasis in spinal column — DURATION: 9 mo

Due to:

Due to:

Other conditions: hypostatic pneumonia 4 days

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: D. V. Stohler M.D.
M. D. or other
Address: Delmar Del Date signed 12-10-47

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11750

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:

County: Wicomico

City or town: Allen Md - P.O. Eden

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? about 17 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Wicomico

City or town: Eden - near Allen

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: Elmira White

3. (b) Social Security Number: 215-16-3101

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	a a	married

6.(b) Name of husband or wife: George Gilbert White

6.(c) If alive, give age: Don't know years

7. Birth date of deceased (mo., day, yr.): June 10 1858

8. AGE: Years	Months	Days	If less than one day
59	6	21	hrs. min.

9. Birthplace: Wilmington, New Castle Co. Del. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Same

FATHER

12. Name: Joseph Smith

13. Birthplace: Don't know

MOTHER

14. Maiden name: Elizabeth Smith

15. Birthplace: Don't know

16. Informant: Geo. Gilbert White

Address: Eden, Md. Box 62

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan 4-48 (month) (day) (year)

Cemetery or crematory: Green Acres Memorial Park

Location: Salisbury, Maryland

18. Funeral director: James F. Stewart

Address: 402 E. Church St. Salisbury, Md.

19. 1/4, 1948 (Date rec'd by registrar) Isaac Ed. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 30 1947 at 10:42 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec-7 1947 to Dec 30 1947 and that I last saw h.. alive on Dec. 30 1947

Immediate cause of death	DURATION
Diabetes mellitus	Lifetime
Due to: Diabetic coma	4 hrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. Purnell, M.D. (M. D. or other)

Address: 800 Main Date signed: 1/5/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a 11722

CERTIFICATE OF DEATH

Reg. Dist. No. 733

1. PLACE OF DEATH: County: Wicomico Co. City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month

Hospital, institution, or street address where death occurred: Wicomico Nursing Home

How long in hospital or institution? 1 month

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury (If outside city or town limits, write RURAL and give nearest town)

Street No.: 604 Isabella St. / Poplar Hill Ave (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: A. Blanche Williams

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Jay Williams 6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): Feb. 18-1867

8. AGE: Years: 80 Months: 10 Days: 11 If less than one day: hrs. min.

9. Birthplace: Royal Oak Wico. Co. Md. (Town, county, and state)

10. Usual occupation: Home life

11. Industry or business:

FATHER — 12. Name: Alexander Catlin

13. Birthplace: Wico. Co. Md.

MOTHER — 14. Maiden name: Mary Wesley Willing

15. Birthplace: Mount Vernon Md

16. Informant: Mrs. Elizabeth O. Williams

Address: Isabella St. & Poplar Hill Ave Salisbury Md

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Dec. 31-1947 (month) (day) (year)

Cemetery or crematory: Parsons Cem.

Location: Salisbury Maryland

18. Funeral director: Fitzgerald & Walter R. Fitzgerald

Address: Salisbury Maryland.

19. 12/31/47 (Date rec'd by registrar) Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 29th 1947 at 10 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 14 1947 to December 29 1947 and that I last saw h... alive on December 28 1947

Immediate cause of death: Hemorrhage Multiple into brain Subdural

	DURATION
Due to: Arteriosclerosis & abscess of brain	
Due to: arteriosclerosis & kidney	
Other conditions: Veins in legs	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Nature of injury: Injured at work?

23. SIGNATURE: C. J. Deare M. D. or other

Address: 213 W. Church St. Salisbury Md Date signed

VS A15 9-45-15M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1952

11723

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Allen Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred: no
How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Allen Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.: no
(If rural, give LOCATION)
2.(a) If veteran, name war: no

3.(a) FULL NAME Earl Elisha Williams

3.(b) Social Security Number 219-14-3139

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	a.a.	Married

6.(b) Name of husband or wife: Minnie Williams
6.(c) If alive, give age: Yes no years

7. Birth date of deceased (mo., day, yr.): Sept 19 1899

8. AGE: Years	Months	Days	If less than one day
48	—	—	...hrs. ...min.

9. Birthplace: Allen Md
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Same as above

FATHER
12. Name: Lafayette Williams
13. Birthplace: Allen Md

MOTHER
14. Maiden name: Martha J Polk
15. Birthplace: Allen Md

16. Informant: Mrs Martha J Polk
Address: Allen Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 9 - 47 (month) (day) (year)
Cemetery or crematory: Friendship Cem
Location: Allen Md
18. Funeral director: James D Stewart
Address: Salisbury Md

19. 12/9 19... W. Earnest E. Johnson Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 5, 1947, at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 11, 1947, to Dec 5, 1947 and that I last saw h... alive on Dec 5, 1947

Immediate cause of death	DURATION
Paraplegia Lower Extem -	
Partial Upper Extremities	
Due to: Injury following	
Hospital Holiday	
Due to:	
Other conditions: not known	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.: —
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: Sept 11, 1947
Where did injury occur? Salisbury - Allen Rd. Wicomico Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): On Highway
Means of injury: Struck by car head + shoulder Injured at work? no

23. SIGNATURE: G K Sembly MD
M. D. or other
Address: Salisbury Md Date signed: 12/9/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

11724

CERTIFICATE OF DEATH

Reg. Diat. No. 333

1. PLACE OF DEATH:
County: Wicomico
City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 77 years
Hospital, institution, or street address where death occurred: Nursing Home, Salisbury, Md. Rd. 1
How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Wicomico
City or town: Salisbury, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 609 Poplar Hill Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Ester Hardy Williams

3.(b) Social Security Number: ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Mr. Williams
6.(c) If alive, give age: ✓ years

7. Birth date of deceased (mo., day, yr.): about 1870

8. AGE: Years: about 77 | Months: ✓ | Days: ✓ | If less than one day: ✓ hrs. ✓ min.

9. Birthplace: Salisbury, Wicomico, Md. (town, county, and state)

10. Usual occupation: At Home

11. Industry or business: ✓

FATHER
12. Name: Not Known
13. Birthplace:

MOTHER
14. Maiden name: Mary Fowler
15. Birthplace: Salisbury, Md.

16. Informant: Gordon L. Hardy
Address: 7340 Chilton St., Phila. Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/2/48 (month) (day) (year)
Cemetery or crematory: Green Acres
Location: Salisbury, Md.

18. Funeral director: W. Hall Johnson Co.
Address: Salisbury, Md.

19. 1/2, 1948 (Date rec'd by registrar) Rebecca L. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 30, 1947, at 11 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 27, 1947 to Dec. 30, 1947 and that I last saw h[illegible] alive on Dec. 30, 1947

Immediate cause of death	DURATION
Arteriosclerotic Heart Disease	4 mo.
Due to: Arteriosclerosis.	over 1 year
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: E. A. Purnell, M.D.
M. D. or other
Address: 800 W. Main
Date signed: 1/2/48

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

11725

Reg. Dist. No. 333

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 21 years
Hospital, Institution, or street address where death occurred:
RFD # 2
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. RFD # 2
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Norma Lee Wilson

3.(b) Social Security Number 215-20-0617

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Ralph Wilson
6.(c) If alive, give age 21 years

7. Birth date of deceased (mo., day, yr.) June 26, 1926

8. AGE: Years	Months	Days	If less than one day
21			hrs. min.

9. Birthplace Salisbury, Md.
(Town, county, and state)
10. Usual occupation House work
11. Industry or business Home
FATHER 12. Name Walter Hatten
13. Birthplace Wicomico County, Md.
MOTHER 14. Maiden name Clara Colona
15. Birthplace Wicomico County, Md.
18. Informant Ralph Wilson
Address Salisbury, Maryland RFD # 2
17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-4-47 (month) (day) (year)
Cemetery or ~~Crematory~~ Parsons
Location Salisbury Md
18. Funeral director W. L. Shaw & Co
Address Delmar Delaware
19. 12/4/47 (Date rec'd by registrar) Harriet L. Johnson Registrar

MEDICAL CERTIFICATION P

20. DATE OF DEATH Dec. 1 19 47, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 30 19 47, to Dec 1 19 47
and that I last saw her alive on Dec 1 19 47

Immediate cause of death	DURATION
Pulmonary Hemorrhage	Hours
Due to Probably TBC.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. W. Mack M. D. or other
Address Salisbury Date signed 12/11/47

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46b 11726

CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: Wicomico
County
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution or street address where death occurred: 610. Brown st.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Wicomico
City or town Salisbury
(If outside city or town limits, write RURAL and give nearest town)
Street No. 610. Brown st.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Lina May Wingate

3.(b) Social Security Number

4. Sex: Female | 5. Color or race: White | 6.(a) Single, married, widowed, or divorced: Widow

6.(b) Name of husband or wife: Alexander Wingate

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): June 4-1868

8. AGE: Years: 79 | Months: 6 | Days: 17 | If less than one day: hrs. min.

9. Birthplace: R.D. Fruitland Md
(Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business: at Home

FATHER
12. Name: Samuel Smith
13. Birthplace: Allen Md.

MOTHER
14. Maiden name: Sarah Carey
15. Birthplace: Allen Md.

16. Informant: Mr. John H. Davis
Address: 706 Brown st. Salisbury Md

17. Burial, cremation, or removal (Which?) Burial Date thereof: Dec. 24-1947
(month) (day) (year)
Cemetery or crematory: Parsons Cem.
Location: Salisbury Md

18. Funeral director: Holloway & Walter R. Holloway
Address: Salisbury Md.

19. (Date rec'd by registrar) 12/26/47 Harriet E. Johnson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 21st 1947 at 11.15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 19 to Dec. 21 19; and that I last saw h alive on 19

	DURATION
Immediate cause of death: Coronary Thrombosis	Sudden death
Due to:	
Due to:	
Other conditions: Carcinoma of Stomach	6 mos

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. A. Anderson M.D. Deputy Medical Examiner

M. D. or other

Address: Salisbury Md Date signed 12/23/47

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131b

11727

Reg. Diat. No. 2337

1. PLACE OF DEATH

County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Walnut Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For nonresident infants give residence of mother)

State: Md. County: Wicomico

City or town: Salisbury

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Walnut Street

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Cornelia Mae Wootten

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Charles D. Wootten

6.(c) If alive, give age: Dead years

7. Birth date of deceased (mo., day, yr.): June 10 1869

8. AGE: Years: 78 Months: 6 Days: 0 If less than one day: hrs. min.

9. Birthplace: R.D. Pittsville Md.

(Town, county, and state)

10. Usual occupation: Home

11. Industry or business:

FATHER — 12. Name: Henry Holloway

13. Birthplace: Wicomico Co. Md

MOTHER — 14. Maiden name: Elizabeth Hall

15. Birthplace: Wicomico Co. Md

16. Informant: Miss Mabel Wootten

Address: Walnut St. Salisbury Md

17. Burial (Burial, cremation, or removal): Date thereof: Dec 12 1947 (month) (day) (year)

Cemetery or crematory: Pittsville

Location: Pittsville Md.

18. Funeral director: Holloway & Co. Walter R. Holloway

Address: Salisbury Md.

19. 12/12/47 (Date rec'd by registrar) H. C. Harris Asst. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 10th 1947 at 1205 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 1942 to Dec 10 1947 and that I last saw h[illegible] alive on Dec 10 1947

Immediate cause of death	DURATION
Myocarditis Coronary	4 days
Due to Chronic Nephritis	2 yrs
Due to Rheumatoid Arthritis	13 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. H. Lynch M. D. or other

Address: Salisbury Md. Date signed: Dec 12/47

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Incorrect age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING